



COMPOUNDING SELF-ASSESSMENT

The California Code of Regulations section 1735.2 requires the pharmacist-in-charge of each pharmacy licensed under section 4037 or 4029 of the Business and Professions Code that compounds drug products to complete a self-assessment of the pharmacy's compliance with federal and state pharmacy law. **The assessment shall be performed before July 1 of every odd-numbered year.** The pharmacist-in-charge must also complete a self-assessment within 30 days whenever; (1) a new pharmacy permit has been issued, or (2) there is a change in the pharmacist-in-charge; or (3) there is a change in the licensed location of the pharmacy. The primary purpose of the self-assessment is to promote compliance through self-examination and education.

The self-assessment must be completed in entirety and may be completed online, printed and retained in the pharmacy. Do not copy a previous assessment.

Each self-assessment must be kept on file in the pharmacy for three years after it is performed.

Pharmacy Name: _____

Address: _____ Phone: _____

Ownership: Sole Owner ☐ Partnership ☐ Corporation ☐ LLC ☐
Non-Licensed Owner ☐ Other (please specify) ☐ _____

Permit #: _____ Exp. Date: _____ Other Permit #: _____ Exp. Date: _____

Licensed Sterile Compounding Permit # _____ Expiration: _____

or Accredited by: _____ From: _____ To: _____

DEA Registration #: _____ Exp. Date: _____ Date of DEA Inventory: _____

Hours: Daily _____ Sat _____ Sun. _____ 24 Hours _____

PIC: _____ RPH # _____ Exp. Date: _____

Pharmacy Staff (pharmacists, intern pharmacists, pharmacy technicians assigned to compounding duties):
(Please use an additional sheet if necessary)

2.	_____	RPH # _____	Exp. Date: _____
3.	_____	RPH # _____	Exp. Date: _____
4.	_____	RPH # _____	Exp. Date: _____
5.	_____	RPH # _____	Exp. Date: _____
6.	_____	RPH # _____	Exp. Date: _____
7.	_____	INT # _____	Exp. Date: _____
8.	_____	INT # _____	Exp. Date: _____
9.	_____	INT # _____	Exp. Date: _____
10.	_____	TCH # _____	Exp. Date: _____
11.	_____	TCH # _____	Exp. Date: _____
12.	_____	TCH # _____	Exp. Date: _____
13.	_____	TCH # _____	Exp. Date: _____
14.	_____	TCH # _____	Exp. Date: _____
15.	_____	TCH # _____	Exp. Date: _____
16.	_____	TCH # _____	Exp. Date: _____

COMPOUNDING SELF-ASSESSMENT

All references to the California Code of Regulations (CCR) are to Title 16 unless otherwise noted.

Please mark the appropriate box for each question. If "NO", enter an explanation on "CORRECTIVE ACTION OR ACTION PLAN" lines at the end of the section. If more space is needed, you may add additional sheets.

ALL COMPOUNDING Complete Sections 1 through 8.

1. Definitions (CCR 1735 and 1735.1)

Yes No N/A

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1.1. The pharmacy compounds prescriptions as defined in CCR 1735.

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1.2. The compounding pharmacist understands the definitions of equipment, integrity, potency, quality and strength as defined in CCR 1735.1.

2. Compounded Limitations and Requirements (CCR 1735.2)

The pharmacy does not compound drug product prior to receipt of a valid prescription unless under the following conditions. (CCR 1735.2[a])

Yes No N/A

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2.1. The pharmacy prepares and stores a limited quantity of a compounded drug product in advance of receipt of a patient specific prescription solely in such quantity as is necessary to ensure continuity of care of an identified patient population as defined. (CCR 1735.2[b])

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2.2. The pharmacy compounds a reasonable quantity of drug product that is furnished to a prescriber for office use upon prescriber order as allowed in CCR 1735.2 (c) that:

- ☐ 2.2.1. Is sufficient for administration or application to patients in the prescriber's office or for distribution of not more than a 72-hour supply, (CCR 1735.2[c][1])
- ☐ 2.2.2. Is reasonable considering the intended use of the compounded medication and the nature of the prescriber's practice, (CCR 1735.2[c][2]) AND
- ☐ 2.2.3. Is an amount, which the pharmacy is capable of compounding in compliance with pharmaceutical standards for integrity, potency, quality and strength for any individual prescriber or for all prescribers taken as a whole. (CCR 1735.2[c][3])

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2.3. The pharmacy does not compound medication until it has prepared a written master formula that includes the following elements (CCR 1735.2[d][1-6]):

- ☐ 2.3.1. Active ingredients used.
- ☐ 2.3.2. Equipment to be used.
- ☐ 2.3.3. Expiration dating requirements.
- ☐ 2.3.4. Inactive ingredients used.
- ☐ 2.3.5. Process and/or procedure used to prepare the drug.
- ☐ 2.3.6. Quality reviews required at each step in the preparation of the drug.
- ☐ 2.3.7. Post-compounding process or procedures if required.

Yes No N/A

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2.4. The master formula for a drug product that is not routinely compounded by the pharmacy is recorded on the prescription document itself. (CCR 1735.2 [e])

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2.5. All chemicals, bulk drug substances, drug products and other components for compounding are stored and used according to compendia and other applicable requirements to maintain their integrity, potency, quality and labeled strength. (CCR 1735.2 [g])

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2.6. Compounded drug products are given an expiration date representing the date beyond which, in the professional judgment of the pharmacist performing or supervising the compounding, it should not be used. The "beyond use date" of the compounded drug product does not exceed 180 days from preparation or the shortest expiration date of any component in the compounded drug product, unless a longer date is supported by stability studies of finished drugs or compounded drug products using the same components and packaging. Shorter dating may be used if it is deemed appropriate in the professional judgment of the responsible pharmacist. (CCR 1735.2[h])

CORRECTIVE ACTION OR ACTION PLAN: _____

3. Records of Compounded Drug Products (CCR 1735.3)

Yes No N/A

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3.1. A record for each compounded drug product includes the following (CCR 1735.3[a][1-10]):

☐ 3.1.1. The master formula record.

☐ 3.1.2. The date the drug product was compounded.

☐ 3.1.3. The identity of the pharmacy personnel who compounded the drug product.

☐ 3.1.4. The identity of the pharmacist reviewing the final drug product.

☐ 3.1.5. The quantity of each component used in compounding the drug product.

☐ 3.1.6. The manufacturer or supplier, expiration date and lot number of each component.

Exempt from this requirement are sterile drug products compounded on a one-time basis for administration within seventy-two (72) hours and stored in accordance with standards for "Redispensed CSPs" found in Chapter 797 of the United States Pharmacopeia – National Formulary (USP-NF) (35th Revision, Effective May 1, 2012), to an inpatient in a health care facility licensed under section 1250 of the Health and Safety Code.

☐ 3.1.7. The pharmacy assigned reference or lot number for the compounded drug product.

☐ 3.1.8. The expiration date of the final compounded drug product.

☐ 3.1.9. The quantity or amount of drug product compounded.

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3.2. The pharmacy maintains records of the proper acquisition, storage, and destruction of chemicals, bulk drug substances, drug products and components used in compounding. (CCR 1735.3 [b])

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3.3. Chemicals, bulk drug substances, drug products, and components used to compound drug products are obtained from reliable suppliers. (CCR 1735.3 [c])

Yes No N/A

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3.4. The pharmacy acquires and retains any available certificates of purity or analysis for chemicals, bulk drug substances, drug products and components used in compounding. (This is not a requirement for drug products approved by the FDA.) (CCR 1735.3 [c])

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3.5. The pharmacy maintains and retains all records required in the pharmacy in a readily retrievable form for at least three years (CCR 1735.3 [d]).

4. **Labeling of Compounded Drug Products (CCR 1735.4)**

Yes No N/A

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4.1. The label of the compounded drug product contains the generic name(s) of the principle active ingredient(s). (CCR 1735.4[a])

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4.2. The prescription label contains all the information required in B&PC 4076 and is formatted in accordance with CCR 1707.5. (CCR 1735.4[a])

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4.3. If requested by the patient, the prescription label is printed in 12-point typeface. (CCR 1707.5[a])

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4.4. The pharmacy is exempt from the prescription label requirements in CCR 1707.5. (B&PC 4076.5[d])

Exemption approved by the board from: _____ to: _____

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4.5. The container or receipt contains a statement that the drug has been compounded by the pharmacy. (CCR 1735.4[b])

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4.6. Drug products compounded into unit-dose containers that are too small or otherwise impractical for full compliance with the requirements of [a] and [b] are labeled with at least the name(s) of the active ingredient(s), concentration of strength, volume or weight, pharmacy reference or lot number, and expiration date. (CCR 1735.4[c])

CORRECTIVE ACTION OR ACTION PLAN: _____

5. **Compounding Policies and Procedures (CCR 1735.5)**

Yes No N/A

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5.1. The pharmacy maintains a written policy and procedure manual for compounding that establishes the following (CCR 1735.5 [a]):

☐ 5.1.1. Procurement procedures.

☐ 5.1.2. Methodologies for the formulation and compounding of drugs.

☐ 5.1.3. Facilities and equipment cleaning, maintenance and operations.

☐ 5.1.4. Other standard operating procedures related to compounding.

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5.2. The policy and procedure manual is reviewed on an annual basis by the pharmacist-in-charge and is updated whenever changes in process are implemented. (CCR 1735.5 [b])

Yes No N/A

- ☐☐☐ 5.3. The policy and procedure manual includes procedures for notifying staff assigned to compounding duties of any changes in process or to the policy and procedure manual. (CCR 1735.5[c][1])
- ☐☐☐ 5.4. The manual includes documentation of a plan for recall of a dispensed compounded drug product where subsequent verification demonstrates the potential for adverse effects with continued use of a compounded drug product. (CCR 1735.5[c][2])
- ☐☐☐ 5.5. The manual includes procedures for maintaining, storing, calibrating, cleaning and disinfecting equipment used in compounding and for training on these procedures. (CCR 1735.5[c][3])
- ☐☐☐ 5.6. The manual includes documentation on the methodology used to test integrity, potency, quality and labeled strength of compounded drug products. (CCR 1735.5[c][4])
- ☐☐☐ 5.7. The manual includes documentation of the methodology used to determine appropriate expiration dates for compounded drug products. (CCR 1735.5[c][5])

CORRECTIVE ACTION OR ACTION PLAN: _____

6. **Compounding Facilities and Equipment (CCR 1735.6)**

Yes No N/A

- ☐☐☐ 6.1. The pharmacy maintains written documentation regarding the facilities and equipment necessary for safe and accurate compounded drug products to include records of certification of facilities or equipment, if applicable. (CCR 1735.6[a])
- ☐☐☐ 6.2. All equipment used to compound drug products is stored, used and maintained in accordance with manufacturers' specifications. (CCR 1735.6[b])
- ☐☐☐ 6.3. All equipment used to compound drug products is calibrated prior to use to ensure accuracy. (CCR 1735.6[c])
- ☐☐☐ 6.4. Documentation of each calibration is recorded in writing and maintained and retained in the pharmacy. (CCR 1735.6[c])

CORRECTIVE ACTION OR ACTION PLAN: _____

7. **Training of Compounding Staff (CCR 1735.7)**

Yes No N/A

- ☐☐☐ 7.1. The pharmacy maintains written documentation sufficient to demonstrate that pharmacy personnel have the skills and training required to properly and accurately perform assigned responsibilities relating to compounding. (CCR 1735.7[a])
- ☐☐☐ 7.2. The pharmacy develops and maintains an on-going competency evaluation process for pharmacy personnel involved in compounding. (CCR 1735.7[b])

Yes No N/A

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7.3. Documentation on any and all such training for pharmacy personnel is maintained. (CCR 1735.7[b])

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7.4. Pharmacy personnel assigned to compounding duties demonstrate knowledge about processes and procedures used in compounding prior to compounding any drug product. (CCR 1735.7[c])

CORRECTIVE ACTION OR ACTION PLAN: _____

8. Compounding Quality Assurance (CCR 1735.8)

Yes No N/A

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8.1. The pharmacy maintains as part of its written policies and procedures, a written quality assurance plan to monitor and ensure the integrity, potency, quality and labeled strength of compounded drug products. (CCR 1735.8[a])

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8.2. The pharmacy's quality assurance plan includes the written procedures and standards for the following:

- ☐ 8.2.1. Verification, monitoring and review of the adequacy of the compounding processes as well as documentation of review of those processes by qualified pharmacy personnel. (CCR 1735.8[b])
- ☐ 8.2.2. Qualitative and quantitative integrity, potency, quality and labeled strength analysis of compounded drug products. (CCR 1735.8[c])
- ☐ 8.2.3. Such reports are retained by the pharmacy and collated with the compounding record and master formula. (CCR 1735.8[c])
- ☐ 8.2.4. Scheduled action in the event any compounded drug product is ever discovered to be below minimum standards for integrity, potency, quality or labeled strength. (CCR 1735.8[d])

(Continued on Next Page)

COMPOUNDING STERILE INJECTABLE DRUGS

Does the pharmacy compound sterile injectable drugs? ☐ Yes ☐ No

If yes, complete Sections 9 through 19.

9. FOR PHARMACIES THAT COMPOUND STERILE INJECTABLE DRUGS: Permit or Accreditation

Yes No N/A

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The pharmacy has a board issued Licensed Sterile Compounding permit or has current accreditation from the Joint Commission on Accreditation of Healthcare Organizations, or other board approved accreditation agency. (B&PC 4127.1[a] and 4127.1[d])

LSC # _____ OR

Name of accreditation agency _____

10. Compounding Drug for Other Pharmacy for Parenteral Therapy (B&PC 4123)

Yes No N/A

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10.1. The pharmacy contracts to compound a drug for parenteral therapy, pursuant to a prescription, for delivery to another pharmacy.

- ☐ 10.1.1. The contractual arrangement is reported to the board within 30 days of commencing that compounding.

11. Sterile Injectable Compounding; Compounding Area (CCR 1751)

Yes No N/A

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11.1. If the pharmacy compounds sterile injectable drugs from a nonsterile source, the pharmacy has a designated area or cleanroom for the preparation of sterile products that has one the following:

- ☐ 11.1.1. An ISO class 5 laminar airflow hood within an ISO class 7 cleanroom. A positive air pressure differential in the cleanroom that is relative to adjacent areas; (B&PC 4127.7[a])
- ☐ 11.1.2. An ISO class 5 cleanroom (B&PC 4127.7[b])
- ☐ 11.1.3. A barrier isolator that provides an ISO class 5 environment for compounding. (B&PC 4127.7[c])

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11.2. The cleanroom walls, ceiling and floors are made of non-porous, cleanable surfaces and the room is well ventilated (CCR 1751)

- ☐ 11.2.1. The laminar airflow hoods and clean room are certified annually; (CCR 1751)
- ☐ 11.2.2. Supplies are stored in a manner, which maintains integrity of an aseptic environment; (CCR 1751)
- ☐ 11.2.3. A sink with hot and cold running water; (CCR 1751)
- ☐ 11.2.4. A refrigerator of sufficient capacity to meet the storage requirements for all material requiring refrigeration. (CCR 1751)

CORRECTIVE ACTION OR ACTION PLAN: _____

12. **Sterile Injectable Recordkeeping Requirements. (CCR 1751.1)**

Yes No N/A

- ☐ ☐ ☐ 12.1. Pharmacy records are made and kept for sterile injectable products produced for future use (pursuant to section 1735.2), in addition to record requirements of section 1735.3, contain the name, lot number, amount, and date on which the products were provided to a prescriber. (CCR 1751.1[a])
- ☐ ☐ ☐ 12.2. Records for sterile products compounded from one or more non-sterile ingredients are made and kept and contain the following: (CCR 1751.1[b][1-6])
- ☐ 12.2.1. The training and competency evaluation of employees in sterile product procedures;
 - ☐ 12.2.2. Refrigerator and freezer temperatures;
 - ☐ 12.2.3. Certification of the sterile compounding environment;
 - ☐ 12.2.4. Other facility quality control logs specific to the pharmacy's policies and procedures (e.g., cleaning logs for facilities and equipment);
 - ☐ 12.2.5. Inspection for expired or recalled pharmaceutical products or raw ingredients; and
 - ☐ 12.2.6. Preparation records including the master work sheet, the preparation work sheet, and records of end-product evaluation results.
- ☐ ☐ ☐ 12.3. The pharmacy maintains and retains all records required in the pharmacy in a readily retrievable form for at least three years from the date the record was created. (CCR 1751.1[c])

CORRECTIVE ACTION OR ACTION PLAN: _____

13. **Sterile Injectable Labeling Requirements (CCR 1751.2)**

Yes No N/A

- ☐ ☐ ☐ 13.1. In addition to the labeling information required under Business and Professions Code section 4076 and CCR 1735.4, the pharmacy's compounded sterile injectable product labels contain: (CCR 1751.2[a-d])
- ☐ 13.1.1. Telephone number of the pharmacy, unless dispensed for a hospital in-patient;
 - ☐ 13.1.2. Name and concentrations of ingredients contained in the product;
 - ☐ 13.1.3. Instructions for storage and handling; and
 - ☐ 13.1.4. A special label that states "Chemotherapy—Dispose of Properly" or "Cytotoxic – Dispose of Properly" for all cytotoxic agents.

CORRECTIVE ACTION OR ACTION PLAN: _____

14. **Sterile Injectable Policies and Procedures (CCR 1751.3)**

Yes No N/A

- ☐☐☐ 14.1. The pharmacy has a written manual documenting the policies and procedures associated with the preparation and dispensing of sterile injectable products and, in addition to the elements required by section 1735.5, includes: (CCR 1751.2[a][1-7])
- ☐ 14.1.1. Compounding, filling, and labeling of sterile injectable compounds;
 - ☐ 14.1.2. Labeling of the sterile injectable product based on the intended route of administration and recommended rate of administration;
 - ☐ 14.1.3. Equipment and supplies;
 - ☐ 14.1.4. Training of staff in preparation of sterile injectable products;
 - ☐ 14.1.5. Training of patient and/or caregiver in the administration of compounded sterile injectable products;
 - ☐ 14.1.6. Procedures for the handling and disposal of cytotoxic agents;
 - ☐ 14.1.7. Quality assurance program; and
 - ☐ 14.1.8. Record keeping requirements.
- ☐☐☐ 14.2. Ingredients and compounding process for each preparation is determined in writing and reviewed by a pharmacist before compounding begins. (CCR 1751.3[b])
- ☐☐☐ 14.3. Policies and procedures address the disposal of infectious materials and/or materials containing cytotoxic residues and include cleanup of spills in conformance with local health jurisdictions. (CCR 1751.3 [c])
- ☐☐☐ 14.4. If compounding sterile injectable products from one or more non-sterile ingredients, the pharmacy has written policies and procedures that comply with the following: (CCR 1751.3[d][1-3])
- ☐ 14.4.1. Policies and procedures are immediately available to all compounding personnel and board inspectors (CCR 1751.3[d][1]); and
 - ☐ 14.4.2. All compounding personnel have read the policies and procedures, any additions, revisions, and deletions before compounding. (CCR 1751.3 [d][2])
- ☐☐☐ 14.5. Policies and procedures address the following: (CCR 1751.3 [d][3] [A-K])
- ☐ 14.5.1. Competency evaluation;
 - ☐ 14.5.2. Storage and handling of products and supplies;
 - ☐ 14.5.3. Storage and delivery of final products;
 - ☐ 14.5.4. Process validation;
 - ☐ 14.5.5. Personnel access and movement of materials into and near the controlled area;
 - ☐ 14.5.6. Use and maintenance of environmental control devices used to create the critical area for manipulation of sterile products (e.g., laminar-airflow workstations, biological safety cabinets, class 100 cleanrooms, and barrier isolator workstations);

- ☐ 14.5.7. A regular cleaning schedule for the controlled area and any equipment in the controlled area and the alternation of disinfectants. Pharmacies subject to an institutional infection control policy may follow that policy as it relates to cleaning schedules;
- ☐ 14.5.8. Disposal of packaging materials, used syringes, containers, and needles to enhance sanitation and avoid accumulation in the controlled area;
- ☐ 14.5.9. For sterile batch compounding, written policies and procedures for the use of master formulas and work sheets and for appropriate documentation;
- ☐ 14.5.10. Sterilization; and
- ☐ 14.5.11. End-product evaluation and testing.

CORRECTIVE ACTION OR ACTION PLAN: _____

15. **Facility & Equipment Standards for Sterile Injectable Compounding (CCR 1751.4)**

Yes No N/A

- ☐☐☐ 15.1. The compounding environment meets criteria specified in the pharmacy's written policies and procedures for safe compounding of sterile injectable drugs. (CCR 1751.4[a])
- ☐☐☐ 15.2. Only those who are properly attired pursuant to (CCR 1751.5) are allowed in the cleanroom during the preparation of sterile injectable products. (CCR 1751.4[b])
- ☐☐☐ 15.3. All equipment used in the designated area or cleanroom is made of easily cleaned and disinfected material. (CCR 1751.4[c])
- ☐☐☐ 15.4. Exterior workbench surfaces and other hard surfaces in the designated area, such as walls, floors, ceilings, shelves, tables, and stools are disinfected weekly and after any unanticipated event that could increase risk of contamination (CCR 1751.4[d])
- ☐☐☐ 15.5. The preparation of parenteral cytotoxic agents is done in accordance with Section 505.5.1 of Title 24, Chapter 5, of the California Code of Regulations and includes: (CCR 1751.4[e])
 - ☐ 15.5.1. A laminar airflow hood, which is certified annually.
 - ☐ 15.5.2. Certification records are maintained for at least three years.

CORRECTIVE ACTION OR ACTION PLAN: _____

16. **Sterile Injectable Compounding Attire (CCR 1751.5)**

Yes No N/A

- ☐☐☐ 16.1. When preparing cytotoxic agents, gowns and gloves are worn. (CCR 1751.5[a])
- ☐☐☐ 16.2. When compounding sterile products from one or more non-sterile ingredients and a barrier isolator is not used: (CCR 1751.5[b][1-5])

- ☐ 16.2.1. Cleanroom garb is donned and removed outside the designated area; (CCR 1751.5[b][2])
- ☐ 16.2.2. Individuals in the cleanroom wear a low-shedding coverall, head cover, face mask, and shoe covers; (CCR 1751.5[b][1])
- ☐ 16.2.3. No hand, finger, or wrist jewelry is worn or if the jewelry cannot be removed, it is cleaned and covered with a sterile glove; (CCR 1751.5[b][3])
- ☐ 16.2.4. Head and facial hair is kept out of critical area or covered (CCR 1751.5[b][4]); and
- ☐ 16.2.5. Gloves of low-shedding material are worn. (CCR 1751.5[b][5])

CORRECTIVE ACTION OR ACTION PLAN: _____

17. **Training of Sterile Injectable Compounding Staff, Patient, and Caregiver (CCR 1751.6)**

Yes No N/A

- | | |
|--|---|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 17.1. Consultation is available to the patient and/or primary caregiver concerning proper use of sterile injectable products and related supplies furnished by the pharmacy. (CCR 1751.6[a]) |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 17.2. The pharmacist-in-charge ensures that all pharmacy personnel engaging in compounding sterile injectable drug products has training and demonstrated competence in the safe handling of those products, including cytotoxic agents if the pharmacy compounds such agents. (CCR 1751.6[b]) |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 17.3. Records of training and demonstrated competence are available for each individual and are retained for three years beyond the employment period. (CCR 1751.6[c]) |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 17.4. The pharmacist-in-charge ensures the continuing competence of pharmacy personnel engaged in compounding sterile injectable products. (CCR 1751.6[d]) |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 17.5. When compounding sterile products from one or more non-sterile ingredients, the pharmacy complies with the following training requirements: (CCR 1751.6[e]) |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | 17.6. The pharmacy follows a written program of training and performance evaluation designed to ensure that each person working in the designated area has the knowledge and skills necessary to perform their assigned tasks properly. This program of training and performance evaluation addresses the following: (CCR 1751.6[e][1][A-J]) <ul style="list-style-type: none"> <input type="checkbox"/> 17.6.1. Aseptic technique; <input type="checkbox"/> 17.6.2. Pharmaceutical calculations and terminology; <input type="checkbox"/> 17.6.3. Sterile product compounding documentation; <input type="checkbox"/> 17.6.4. Quality assurance procedures; <input type="checkbox"/> 17.6.5. Aseptic preparation procedures; <input type="checkbox"/> 17.6.6. Proper gowning and gloving technique; <input type="checkbox"/> 17.6.7. General conduct in the controlled area; <input type="checkbox"/> 17.6.8. Cleaning, sanitizing, and maintaining equipment used in the controlled area; <input type="checkbox"/> 17.6.9. Sterilization techniques; and |

- ☐ 17.6.10. Container, equipment, and closure system selection.

Yes No N/A

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17.7. Each person assigned to the controlled area successfully completes practical skills training in aseptic technique and aseptic area practices. (CCR 1751.6[e][2])

- ☐ 17.7.1. checks involving adherence to aseptic area policies and procedures.
(CCR 1751.6[e][2])
- ☐ 17.7.2. Each person's proficiency and continuing training is reassessed every 12 months.
(CCR 1751.6[e][2])
- ☐ 17.7.3. Results of these assessments are documented and retained in the pharmacy for three years. (CCR 1751.6[e][2])

CORRECTIVE ACTION OR ACTION PLAN: _____

18. Sterile Injectable Compounding Quality Assurance and Process Validation (CCR 1751.7)

Yes No N/A

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18.1. There is a written, documented, ongoing quality assurance program maintained by the pharmacy that monitors personnel performance, equipment, and facilities, and the pharmacist-in-charge assures that the end-product meets the required specifications by periodic sampling.
(CCR 1751.7[a])

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18.2. The Quality Assurance Program contains at least the following: (CCR 1751.7[a][1-4])

- ☐ 18.2.1. Cleaning and sanitization of the parenteral medication preparation area;
- ☐ 18.2.2. The storage of compounded sterile injectable products in the pharmacy and periodic documentation of refrigerator temperature;
- ☐ 18.2.3. Actions to be taken in the event of a drug recall; and
- ☐ 18.2.4. Written justification of the chosen expiration dates for compounded sterile injectable products in accordance with CCR 1735.2[h]).

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18.3. Each individual involved in the preparation of sterile injectable products successfully completes a validation process on technique before being allowed to prepare sterile injectable products.
(CCR 1751.7[b])

- ☐ 18.3.1. The validation process is carried out in the same manner as normal production, except that an appropriate microbiological growth medium is used in place of the actual product used during sterile preparation. (CCR 1751.7[b])
- ☐ 18.3.2. The validation process is representative of all types of manipulations, products and batch sizes the individual is expected to prepare. (CCR 1751.7[b])
- ☐ 18.3.3. The same personnel, procedures, equipment, and materials are involved.
(CCR 1751.7[b])
- ☐ 18.3.4. Completed medium samples are incubated. (CCR 1751.7[b])
- ☐ 18.3.5. If microbial growth is detected, the sterile preparation process is evaluated, corrective action taken, and the validation process is repeated. (CCR 1751.7[b])

- ☐ 18.3.6. Personnel competency is revalidated and documented at least every 12 months, whenever the quality assurance program yields an unacceptable result, when the compounding process changes, equipment used in the compounding of sterile injectable drug products is repaired or replaced, the facility is modified in a manner that affects airflow or traffic patterns, or whenever aseptic techniques are observed. (CCR 1751.7[b])

Yes No N/A

☐☐☐

- 18.4. Batch produced sterile injectable drug products compounded from one or more non-sterile ingredients are subject to documented end product testing for sterility and pyrogens and are quarantined until the end product testing confirms sterility and acceptable levels of pyrogens. (CCR 1751.7[c])

CORRECTIVE ACTION OR ACTION PLAN: _____

19. Sterile Injectable Compounding Reference Materials (CCR 1751.8)

Yes No N/A

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- Current and appropriate reference materials regarding the compounding of sterile injectable products are maintained or immediately available to the pharmacy. (CCR 1751.8)

CORRECTIVE ACTION OR ACTION PLAN: _____

(Continued on next page.)

PHARMACIST-IN-CHARGE CERTIFICATION:

I, (Please print) _____, RPH # _____ hereby certify that I have completed the self-assessment of this pharmacy of which I am the pharmacist-in-charge. Any deficiency identified herein will be corrected. I understand that all responses are subject to verification by the Board of Pharmacy. I further state under penalty of perjury of the laws of the State of California that the information I have provided in this self-assessment form is true and correct.

Signature _____ Date _____

ACKNOWLEDGEMENT BY OWNER OR HOSPITAL ADMINISTRATOR:

I, (please print) _____, hereby certify under penalty of perjury of the laws of the State of California that I have read and reviewed this completed self-assessment. I understand that failure to correct any deficiency identified in this self-assessment could result in the revocation of the pharmacy's license issued by the California State Board of Pharmacy.

Signature _____ Date _____

(Pharmacist-in-Charge)